

## **MAAC Data Recommendations Report**

### **Background:**

Senate File 2418 appropriates general funds to state agencies, including the Department of Human Services and the Iowa Medicaid Program. Section 131 of the bill requires the Medical Assistance Advisory Council (MAAC) executive committee to review data currently being collected and reported, and recommend to the General Assembly any changes to this data for future reporting. The text of Section 131 of SF 2418 follows:

Sec. 131. MEDICAL ASSISTANCE ADVISORY COUNCIL — REVIEW OF MEDICAID MANAGED CARE REPORT DATA. The executive committee of the medical assistance advisory council shall review the data collected and analyzed for inclusion in periodic reports to the general assembly, including but not limited to the information and data specified in 2016 Iowa Acts, chapter 1139, section 93, to determine which data points and information should be included and analyzed to more accurately identify trends and issues with, and promote the effective and efficient administration of, Medicaid managed care for all stakeholders. At a minimum, the areas of focus shall include consumer protection, provider network access and safeguards, outcome achievement, and program integrity. The executive committee shall report its findings and recommendations to the medical assistance advisory council for review and comment by October 1, 2018, and shall submit a final report of findings and recommendations to the Governor and the general assembly by December 31, 2018.

A subcommittee of the MAAC Executive Committee was selected and met four times (up to September 18, 2018) to evaluate the current reports, and develop recommendations on the report for the full MAAC and its Executive Committee's consideration, according to the requirements of section 131.

More specifically, the subcommittee:

- 1) Reviewed the requirements of SF 2418, and 2016 Iowa Acts, chapter 1139, section 93
- 2) Evaluated legislatively required reporting by conducting a thorough review of the existing managed care quarterly reports
- 3) Developed high-level recommendations for future reporting
- 4) Identified high priority categories of reporting as well as suggesting more specific measures to be included in future reporting for the Iowa Health Link program.

### **High Level Recommendations:**

- 1) **Report brevity and focus** – The subcommittee discussed the large number and variety of reports that the Department has made publicly available. While the sheer number and length of reports suggests a high level of transparency in communicating with the public and stakeholders on program performance, the subcommittee also felt that the volume of information can be overwhelming for the public to make good sense of the program. Policymakers and the public would be better served through a refinement of reporting

that helps identify issues of key interest, and organizing this information in a way that promotes better accessibility of information by the public.

- 2) **Interactive report tools** – Rather than print lengthy and static reports, use of technology could assist the public and policymakers in a better understanding of program performance information. A website-based query tool could allow more effective access to information as needed on issues of particular interest. Iowa Medicaid should consider this option as part of system updates, including modernization and modularity of the MMIS.
- 3) **Rolling periods** – While more frequent, quarterly, reporting is valuable, some health care measures require more data to ensure reliable and valid information is available. In other cases, claims-based reporting may require a claims run-out period to ensure that a statistically significant amount of activity in the quarter is available for analysis. For measures requiring multiple reporting periods to ensure reliability and validity, the Department should consider establishing a set of rolling quarters. In this way, more valid data will be made available on a quarterly basis, but reporting will rely on the most recent four quarters of data, for example, to keep the information current and relevant.
- 4) **Trends** – Data can help illuminate issues when it is performance that is being compared to similar factors. For example, presenting information as trends over time would be very valuable in ascertaining performance improvement or degradation. Similarly, information comparing performance to other states, programs or well-established benchmarks can yield insights that point in time information without points of comparison can't provide. **IME Comment:** Good idea in theory. Just a cautionary note about comparing performance with other states: There are so many variables at play both in how states report (see the recent CMS Scorecard footnotes) as well as how they are funded, what populations they serve, what programs they offer, etc. Not that it might not be effective, however this is a very critical concern with state Medicaid directors and has been voiced loudly prior to the CMS scorecard release. (E.g. states with low funding, high poverty, etc. unfairly compared to states with low unemployment and generous legislative funding).
- 5) **Process indicators versus health outcomes** – The program should create a reasonable mix of data points reported which focus on both administrative process indicators (payment timeliness, pre-authorization counts, for example) and health outcomes indicators (Percentage of Live Births that Weighed Less than 2,500 Grams, Beneficiaries who Quit Smoking, for example).

- 6) **Comparability of data between plans** – Efforts to ensure the comparability of data between plans is paramount to providing accurate information. In some cases, where one plan measures a process or outcome differently from another plan, the Department should take action to ensure that the data is collected and reported in a way to ensure that “apples to apples” comparisons are being made. **IME Comment:** We agree that this important data for Iowa Medicaid is published to CMS and NCQA. NCQA publishes plan-specific results. We would recommend that interested parties view this information at the sources rather than the Agency re-publishing results; for example we can provide a link to these sources on our website rather than re-compiling the information. Additionally, the Agency does not have access to the comparative data published on these sites.
- 7) **Comparability of data across state programs** – Organizations like the National Council on Quality Assurance (NCQA) and the National Quality Forum (NQF) have worked to establish standard and valid measure definitions for health care performance across the country. This standardization of measures ensures that national resources have been invested to ensure that measures do, in fact, reflect performance of the health system. Standard measures also ensure that health care providers have a single standard against which to report. Different ways of measuring the same metric cause confusion among health care providers, introduce inefficiencies in collecting and reporting data, and create confusions for information consumers because measures that sound similar are not measuring the same activity.
- 8) **Elimination of measures from current reports** - Where performance is high and has stabilized following the implementation of managed care, consideration should be given to eliminate these in the public reports indicators. These indicators may certainly have administrative importance, but to economize on space, and communicate on those indicators which are meaningful and changing, the Department should be provided some flexibility, with the concurrence of the Medical Assistance Advisory Council, for example, to make these report adjustments. The following indicators in the existing reports are recommended for elimination:
- a. Secret shopper data in the current quarterly report is more useful than all member response timeliness, because data is not changing
  - b. Payment timeliness data in the quarterly reports may reflect payments made but could be partial, incomplete or inaccurate. Measures in the current quarterly report do not reflect these nuances. To better inform quality improvement efforts, perhaps adjustments to these metrics could be made to refocus the data on the particularly services for which payments are timely – hospitalizations, pharmaceuticals, etc.
  - c. Timely submission of files as reported in the quarterly reports are not very useful. Focus could instead be placed on actual utilization data.
  - d. Subcommittee to identify additional metric candidates for elimination (and justification as to why elimination is recommended) which reflect consistently

high performance, several quarters of no material change, or meet other criteria for elimination.

## MAAC MCO Report Modification Recommendations

Measure (Page Number)	Eliminate/Modify	Rationale
MCO Enrollment Data (5,6,8)	Modify	Break Out Data By Specific Program/Waiver Populations
Care Coordination Reporting – Population-Specific Supporting Data (9-10)	Eliminate	Demographic Data of Limited Value, Outcomes Data More Useful
Health Risk Assessments (9)	Eliminate	Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value
Chronic Health Homes – Population-Specific Supporting Data (11)	Eliminate	Demographic Data of Limited Value, Outcomes Data More Useful
Non-LTSS Care Plans – Members with Care Plans Updated Timely (12)	Eliminate	Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value
Non-LTSS Care Plans – Population-Specific Supporting Data (12)	Eliminate	Demographic Data of Limited Value, Outcomes & Member Participation Data More Useful
Integrated Health Homes – Population-Specific Supporting Data (13)	Eliminate	Demographic Data of Limited Value, Outcomes Data More Useful
LTSS/HCBS Care Coordination – Members Assigned a Case Manager	Eliminate	Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value; Member Participation Data More Useful
Community-Based Case Management Ratios (16)	Modify	Break Out Data By Specific Program/Waiver Populations. <b>IME Comment:</b> MCOs do not have waiver-specific case managers so ratios would be artificially low.
HCBS Service Plans Completed Timely (17)	Eliminate	Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value; Alternative Data Metrics of Greater Value
Member Grievance & Appeals – Percentage Resolved within 30 Days (22)	Eliminate	Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value; Alternative Data Metrics of Greater Value
Percentage of Appeals Resolved within 30 Days (24)	Eliminate	Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value; Alternative Data Metrics of Greater Value
Member Helpline – Percentage of Calls Answered Timely (26)	Eliminate	Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value
Provider Helpline – Percentage of Calls Answered Timely (29)	Eliminate	Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value
Pharmacy Services Helpline – Percentage of Calls Answered Timely (31)	Eliminate	Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value
Medical Claims Payment – Clean Claims Paid/Denied within 30 Days/45 days (32)	Eliminate	Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value; Alternative Data Metrics of Greater Value

Medical Claims Status (33)	Modify	Data Insufficient to Provide Value; Additional Data on Suspended & Denied Claims of Greater Value
Provider Adjustments Reprocessed within 30 Days (36)	Eliminate	Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value
Pharmacy Claims Payment – Clean Claims Paid/Denied within 30 Days/45 days (37)	Eliminate	Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value; Alternative Data Metrics of Greater Value
Pharmacy Claims Status (38)	Modify	Data Insufficient to Provide Value; Additional Data on Denied Claims of Greater Value. <b>IME Comment:</b> Top ten denial reasons are already provided, can we have what additional data is being requested?
Value-Added Services (39)	Modify	Data Insufficient to Provide Value; Additional Information on Specific Services of Greater Value
Provider Access Network (40)	Eliminate	Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value
Members with Coverage in Time & Distance Standards (41)	Eliminate	Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value
Prior Auths (Medical) – Percentage Completed Within 14 Days/ 72 Hours (42)	Eliminate	Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value; Alternative Data Metrics of Greater Value
Prior Auth (Medical) Status (43)	Modify	Data Insufficient to Provide Value; Additional Data on Modified & Denied Prior Auths of Greater Value
Prior Auths (Pharmacy) – Percentage Completed Within 24 Hours (44)	Eliminate	Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value; Alternative Data Metrics of Greater Value
Prior Auth (Pharmacy) Status (45)	Modify	Data Insufficient to Provide Value; Additional Information on Specific Arrangements of Greater Value. <b>IME Comment:</b> Unclear what specific arrangements refers to.
VBP Enrollment (46)	Modify	Data Insufficient to Provide Value; Additional Data on Denied Prior Auths of Greater Value <b>IME Comment:</b> This is value-based purchasing. How do PAs relate?
MCO Reported Reserves (51)	Eliminate	DHS Continue to Monitor, But Reporting of Limited Value

- 9) **Meaningful and sufficient data in report** – Some metrics in the current report lack a level of meaningfulness and sufficiency to be important and informative. For example, confusion exists over value-added services in the report. Categories are too broad to be meaningful, and the enrollment counts, as a result, don't provide meaningful and useful information on service use. Similarly, information in the report reflecting the use of value-based purchasing also lacks a level of meaningfulness to provide useful insights into utilization of value-based purchasing to advance quality improvement in the program.

## **Specific Measure Recommendations**

The subcommittee recommends the following as it relates to specific measures:

- 1) The Department identifies existing, nationally endorsed key performance measures in the following categories of health outcomes:
  - a. Overall acute care
  - b. Long Term Supports and Services
  - c. Behavioral Health
  - d. Substance Use Disorder
  - e. Long Term Care
- 2) **Healthcare Effectiveness Data and Information Set (HEDIS)** (this section could use more descriptive information to provide background on HEDIS) Iowa's Medicaid Program requires each managed care organization to be accredited by the National Committee on Quality Assurance (NCQA). Becoming accredited means that MCOs are capable of reporting on a standard list of measures called the Healthcare Effectiveness Data and Information Set (HEDIS). These measures are revised and updated each year, and the 2018 set of measures is included in Appendix A of this report. IME's use of these measures for reporting will ensure reliance on a national standard of measures that will simplify reporting by MCOs and their provider partners, and ensure comparability from state to state in gauging performance of Iowa's plans. **IME Comment:** See comment above recommending that interested parties go to these specific sites to view performance.
- 3) **Beyond HEDIS data, additional information should be incorporated in reports, as follows:**
  - a. **Home and Community-Based Services** (are these the correct LTSS metrics to list?)
    - i. Long-Term Services and Supports (LTSS) Comprehensive Assessment and Update -The percentage of MLTSS plan members 18 years of age and older who have documentation of a comprehensive assessment in a specified timeframe that includes documentation of core elements. (CMS) **IME Comment:** Revised assessments is already in the report under Level of Care Assessments. If the workgroup would like, these can be broken out by waiver/population and or age that can be accommodated.
    - ii. Long-Term Services and Supports (LTSS) Comprehensive Care Plan and Update -The percentage MLTSS plan members 18 years of age and older who have documentation of a comprehensive LTSS care plan in a specified timeframe that includes documentation of core elements. (CMS) **IME Comment:** Revised service plans (care plans) is already in the report under Service Plans. If the workgroup would like these broken down by waiver/population and or age that can be accommodated.

- iii. Long-Term Services and Supports (LTSS) Shared Care Plan with Primary Care Practitioner -The percentage of MLTSS plan members 18 years of age and older with a care plan that was transmitted to their primary care practitioner (PCP) or other documented medical care practitioner identified by the plan member within 30 days its development. (CMS)

4) **Long-Term Services and Supports (LTSS) Reassessment/Care Plan Update after Inpatient Discharge**--The percentage of discharges from inpatient facilities for MLTSS plan members 18 years of age and older for whom a reassessment and care plan update occurred within 30 days of discharge. (CMS) **IME Comment:** Would encourage the use of more outcome based, rather than process measures. Recommendations include:

- Members feel that they are a part of service planning.
- Members feel safe where they live.
- Percent of members who are involved in employment activities.
- Rate of member falls.
- Medication adherence for individuals with behavioral health diagnosis

a. Institutional Care

- i. Align measures with CMS quality measures for long-term institutional care. (Can we say more here) **IME Comment:** According to Medicaid.gov and the Affordable Care Act, Long Term Supports and Services (LTSS) encompasses the continuum of settings institutional to home and community based. Unclear why there is an LTC and LTSS category. Believe the intent may be institutional vs. home and community-based? Unsure though.

**Other Recommendations**

- b. While quarterly reports can be made available through a database of information which provides appropriate patient level protections for confidentiality as dictated by HIPAA, a standard annual report for the program should continue to be provided.
- c. Similarly, if the recommendation to post data on the website and make the information accessible, a more frequent hard copy report may be unnecessary to publish.
- d. Consider including statistics in the current enrollment information that reflect behavioral health and LTSS along with traditional Medicaid enrollment
- e. Consider including B3 report-type data.
- f. Consideration should be given to include health outcomes specific data to individuals receiving health home program benefits.
- g. In the current report sections which recap the “Top 5 Reasons”, including data that would reflect trends over time would be particularly beneficial to show how the processes in the program are changing over time. **IME comment:** For any trending

that is being done and presented, very clear documentation will be needed each time a metric changes.

- h. Fair Hearing data in the current quarterly report should include trends to better show change over time.
- i. Prior Authorization denials in the current report do not provide enough information to be valuable. Reasons for denials also need to be addressed and integrated into MCO, health care provider, and program quality improvement efforts.
- j. Regarding value-added services, meaningful comparisons of these services by MCO are difficult because all these services are not required. Instead, perhaps more granular reporting of the 40 value added services and their connection to “base” benefits, and utilization that supports health improvement might yield more interesting insights. **IME Comment:** Proprietary concern. MCOs have expressed past reservations that publishing granular information on VAS utilization may reduce their competitive ability as the VAS utilization is intended to have real impacts on member health and MLR. We can certainly revisit.